Department of Health and Social Security

# The Role of Psychologists in the Health Services

## Report of the Sub-Committee

*Chairman:*
Professor W. H. Trethowan, CBE, FRCP, FRC Psych

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* Until September 1973.
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# 1. INTRODUCTION

1.1 The Sub-Committee was originally established by the former Standing Mental Health Advisory Committee. The terms of reference were "To consider the role of psychologists in the health services". The Sub-Committee first met in December 1972 and has held 10 meetings in all.

1.2 The very broad terms in which our remit was expressed left us with considerable freedom, both in identifying the questions within the field of health service psychology which were of relevance to our review, and in deciding how they should be approached. In the opening sections of our report we concentrate on setting out these questions as they emerged in the course of our discussions, before going on to consider the evidence we received and, finally, to put forward our own recommendations.

1.3 It is only right that we should acknowledge at the outset the debt we owe to the large number of organisations and individuals who first responded to our initial invitation to submit evidence, and subsequently gave us their comments on the consultation document which we circulated in March 1974 as a preliminary statement of our main conclusions. Without their help we could not effectively have undertaken the initial formulation of the problems, much less have seen our way to the recommendations which we now put forward. The evidence we received from many organisations demonstrated that awareness of, and interest in, the contribution of psychologists to health service work was far from being restricted to their own profession. The widespread interest in the Sub-Committee's activities underlined for us the importance of the field with which we were concerned, and the need to reach decisions on matters affecting the future contribution of psychologists to the National Health Service generally.

# 2. GENERAL BACKGROUND

2.1 We think it will be helpful by way of background to describe briefly some of the main features of psychology as it is practised in the National Health Service and the way in which it has developed in the recent past. In building up a picture of this we have been helped not only by our own experience as individuals but also by the very full information we received from the bodies which gave evidence to us. For reasons which are referred to later in this report, we have devoted our attention mainly to the discipline of clinical psychology, but we are conscious of the relevance to the National Health Service of much of the work of educational and some other psychologists, and the relationship between their work and that of clinical psychologists is among the points considered in our recommendations.

2.2 Clinical psychology is a relative newcomer among health service professions, but one which has developed rapidly in recent years. The concern of clinical psychologists is with the application of the principles of general psychology to problems arising in the National Health Service, and in particular to the treatment and care of patients. The profession is a small one: at 30 September 1973 the number of clinical psychologists employed in the National Health Service in England and Wales (whole-time equivalent) was 585. Nevertheless this represents

a marked increase over the past few years; as recently as 1962 the total was only 198.

2.3 The profession has developed in close association with that of psychiatry and the great majority of the work of clinical psychologists still takes place in the fields of mental illness and mental handicap. The British Psychological Society, in the survey of part of its membership which the Society conducted at our instigation, found that, as a modal figure, 95% of the patients seen by clinical psychologists were referred to them by psychiatrists. There has, however, been a striking change in the nature of the contribution made by psychologists to the treatment of patients. In former times their role consisted largely of undertaking routine psychological measurements, such as intelligence testing, at the request of psychiatrists and other doctors, and represented in effect an ancillary service to the medical profession. Recent years have seen a substantial expansion in the body of psychological knowledge accompanied by the development of new techniques which have major implications for treatment. One of the effects of these developments has been to make psychological assessment, in contrast to the routine testing activities mentioned above, a much more sophisticated process with a wider range of implications both in determining various aspects of individual need and in evaluating the progress of patients and their response to different forms of therapy. At the same time psychologists have developed a number of new forms of treatment, some of which have been widely applied and represent an important addition to the range of therapeutic resources. The methods which have been most extensively applied are those within the broad category of behaviour therapy which encompasses a wide range of procedures. In some circumstances these techniques may be used to assist quite large groups of patients, for example by applying a token economy scheme to a whole hospital ward.

2.4 In the subsequent sections of our report we return in more detail to some of these matters. But this brief account will already, we think, have suggested some of the issues which we have found ourselves examining. The problems in the field of clinical psychology are those which arise when a new professional discipline develops within an existing organisation which has its own established structure. They involve, in particular, the relationship between clinical psychologists and the members of other health service professions, and, more generally, the ways in which it may be desirable for the organisation to adapt itself so that the fullest use is made of new techniques and skills.

2.5 Psychology is only one of a number of fields in which scientific advance has radically changed the range of options available in the treatment of patients. Many of the professions which this has involved were included in the remit of the Zuckerman Committee on Hospital Scientific and Technical Services which reported in 1968. This Committee recommended the establishment of a new Hospital Scientific Service to include among others, physicists and biochemists. The work of clinical psychologists presents, however, certain special features which distinguish them from most of the other classes which were covered by the Zuckerman Committee's review. The most notable of these is the presence, in certain circumstances, of a face-to-face therapeutic relationship between the psychologist and the individual patient, and indeed we have found this factor to be at the root of many of the issues to which our attention as a committee has been directed. The Zuckerman Committee did in fact consider whether clinical

psychologists should be included in the service they proposed but reported that they had been unable to reach a definite conclusion on this point. They proposed that the Government should study the question further in conjunction with the profession, and it was partly in the light of this recommendation that the Standing Mental Health Advisory Committee was invited to undertake the review for which the present sub-committee was appointed.

## 3. THE ISSUES CONSIDERED BY THE SUB-COMMITTEE

3.1 Having considered the general background described in the previous section we were able to reach an initial view on the questions which our review should cover. These may be briefly stated as follows:—

1. The contribution which psychologists should be expected to make in the provision of health services for different age groups, and their relative importance in the treatment of different conditions.
2. The division of psychologists' activities between assessment and diagnosis, treatment and rehabilitation, research and teaching, and any other activities.
3. The kind of organisation of psychology services needed in Regions, Areas and Districts, including in particular the desirability of setting up independent Departments of Psychology.
4. The possible scope for providing services directly to general practitioners, and to social workers, health visitors and any other staff working in the community.
5. Whether psychology services should be provided from a hospital base.
6. The arrangements for referring patients to psychologists from hospital doctors and general practitioners, and whether there should ever be referrals from non-medical sources.
7. The allocation of clinical responsibility for patients referred to psychologists.
8. Desirable levels of staffing.
9. The scope for employing technicians.
10. The contribution of educational psychologists to health services.
11. The staffing and career structure for psychologists within the National Health Service.
12. The desirable scope and content of training for psychologists.
13. The contribution of psychologists to the teaching and training of other professions.
14. The role of psychologists in research.

3.2 Having determined the subjects we wished to consider we prepared a questionnaire which we sent in February 1973 to a selected number of professional and other organisations. A general invitation to submit evidence was also published in the professional press and copies of the questionnaire were also sent to those organisations and individuals who responded. A copy of the questionnaire appears at Appendix A, and a list of all those who gave evidence at Appendix B. (The list of subjects in the preceding paragraph is a somewhat compressed statement of the ground covered by the questionnaire.)

3.3 Before reviewing the evidence we received we should like to set down a few general comments about the scope of our examination as we saw it. We did not consider that we as a sub-committee, or indeed any similar body, could properly attempt to say what the work of psychologists should comprise. This is something which, ultimately, the profession itself is in the best position to judge—although obviously the limits of the profession's responsibilities can only be determined by it in agreement with the other professions and interests concerned. Our aim in asking questions related to this area was to ascertain as far as possible the general state of opinion about the scope of clinical psychologists' work, and any indications of its likely future direction, as a basis for considering their role in the health services more generally.

3.4 At the same time we felt that any evaluation of the role of clinical psychologists must carry with it advice about the way in which their services should be organised, and it is for this reason that we included questions on this subject. We were not, on the other hand, asked to concern ourselves with questions of manpower, and indeed an authoritative view on this would require a broad perspective on health services staffing which we as a group did not possess. We felt it would be wrong, however, to miss the opportunity of finding out whether there were opinions on this subject which could usefully be passed on to the Department of Health and Social Security and the Welsh Office. Similarly, although the question of training involves very broad issues which we could not hope to cover comprehensively, we thought it worth attempting to draw out any general views on its extent and content.

## 4. THE EVIDENCE RECEIVED

4.1 We have already placed on record our gratitude to the many organisations and individuals who responded to our invitation to submit evidence to the sub-committee. We received in all 90 submissions and we were impressed even more by the quality of this evidence, and the careful consideration it reflected on the place of psychologists in the National Health Service, than by its volume. In this section we attempt to summarise the main views which emerged. While we have done our best, within the confines of space, to bring out the most significant points in an impartial way, we are very conscious of the impossibility of fully doing justice to all the views which were put forward. While on many issues the evidence revealed a high degree of unanimity, there was also strong disagreement on a number of matters. Although we have sought in this summary to reflect the range of views as fully as possible, we may occasionally, in emphasising the most widely held opinions, have given the impression that agreement was wider, and conflict less sharp, than was really the case. We must stress, therefore, that in formulating the proposals which are put forward in the following chapter we have tried to take full account of all the evidence we received, and we hope that those who have strongly held views of their own will be prepared to look at these proposals in their overall context as an attempt to find generally acceptable solutions. In any event we hope that all the evidence will be made freely available to any subsequent group which may be asked to look in more detail at some of the points which we have been able to touch on only briefly.

4.2 We must make one further general comment, relating mainly to the views recorded here about the different activities encompassed by the practice of clinical psychology. Our concern as a Sub-Committee was to identify the part played in these activities by psychologists. We are, however, well aware that in practice there is much overlap between the roles of different professions and that skills are often shared by the members of different groups. The fact that some activities are described here in the context of clinical psychology alone arises from the nature of our remit and does not imply that we necessarily see them as the exclusive province of psychologists; nor, we think, would that have been the wish of those whose views are summarised here.

4.3 The following summary broadly follows the sequence of our questionnaire (Appendix A) which most witnesses took as the framework for their comments. In some instances, however, we have grouped together the comments we received on questions which were clearly seen by witnesses to be closely related to each other.

**General comments**

4.4 There was general agreement among our witnesses that the present contribution of psychologists in the health services fell short of what the profession potentially had to offer. In part this was attributed to the inadequacy of the present numbers of clinical psychologists. It was argued, however, that this shortage was itself partly due to a career structure which was not attractive enough, and to the role of the profession having been unduly restricted so that clinical psychology offered insufficient job satisfaction in comparison with other avenues open to psychology graduates.

4.5 A good deal of comment was made about the development of the role of psychologists in the recent past (on which we have already commented briefly in Chapter 2). There was a general view that while there was a continuing need for assessment, it should not be regarded as an end in itself. The contribution of psychologists to therapy was widely discussed and they were seen as playing an important part in the organisation and evaluation of treatment and rehabilitation for many different groups of patients. The field of mental handicap was one in which psychologists were seen as having a specially important part to play and reference was made to recent fundamental policy changes in the care of the mentally handicapped in which psychologists were seen as having been the prime movers.

4.6 Witnesses emphasised as one of the important features of the psychology profession the existence of a basic training in research methods. This was seen as bearing on much of the work of other professions.

4.7 Some witnesses commented on the scope for a contribution by psychologists to the organisation and administration of the establishments in which they work, as something for which their training equipped them.

4.8 Views were also put forward on the balance between work in the hospital setting (which at present occupies virtually the whole of clinical psychologists' activities) and work in the community. Suggestions were made about the provision of services in health centres, family planning clinics and other community settings. It was argued that in this way psychologists might make an important contribution to preventive work.

4.9 The British Psychological Society commented in some detail on the distinctive nature of clinical psychology and the special features which characterise it as a discipline. Firstly, the Society mentioned the attention which psychologists have given to developing systematic methods of scientific enquiry into different aspects of human behaviour. Secondly, there was the fact that these methods were applied to the study of normal as well as disordered psychological functioning. Thirdly, there was the close relationship between clinical psychologists and academic and research psychologists. The clinical psychologist was a channel through which developments in general psychology could be transmitted and used to help patients, either by psychologists themselves or by passing them on to clinical colleagues. Finally, it was argued that clinical psychologists played a part not only in applying the knowledge and methods developed within psychology but also in themselves adding to and developing the sum of knowledge and the range of methods.

**Assessment, diagnosis, treatment and rehabilitation**

4.10 As well as inviting views (which are discussed below) on the actual and potential contribution of psychology in relation to different age-groups and different clinical conditions, we asked for comment on the division of psychologists' activities between assessment, diagnosis, treatment and rehabilitation (and also research). The British Psychological Society, again, commented in some detail on the development of these different fields, and a brief account of some of the points made by the Society may be generally helpful.

4.11 The four broad categories of assessment identified by the Society were psychometric techniques (standardised tests of different psychological functions), physiological measures used as indices of psychological functioning or change, "diagnostic" assessment and, finally, measurement procedures used to reflect the problems and progress of particular patients or groups of patients. The Society emphasised the close relationship between assessment and therapy and the importance of assessment in choosing between alternative forms of treatment.

4.12 In the field of treatment the Society referred in particular to the range of procedures falling under the broad heading of behaviour therapy. The value of these procedures in the treatment of certain conditions, for example phobias, was now well recognised. Operant procedures in particular provided a means of offering treatment to large groups of patients, for example whole wards. Psychologists (together with psychiatrists) were engaged in training nursing and other personnel in the use of some behaviour therapy principles and techniques which could thus be applied more widely.

4.13 The Society also referred to the part played by clinical psychologists in the organisation and evaluation of rehabilitation and training for the mentally and physically handicapped. In addition psychologists were increasingly involved in counselling and related activities. There were various forms of psychological treatment which might be practised by them—generally based on an "educational" or "training" model derived from learning theory. Finally, a very recent development, whose potential was still uncertain, was the use of "experimental group methods" originally developed in training groups or "T-groups".

4.14 One of the questions on which we invited comments from those giving evidence was the desirable division of the time of psychologists between assessment and diagnosis, treatment and rehabilitation, research and any other activi-

ties. Many witnesses pointed out that a precise categorisation of this kind was not possible in a field such as psychology. However the British Psychological Society suggested the following as a rough breakdown of psychologists' time:

| | |
|---|---|
| Assessment and diagnosis | 10% |
| Treatment and rehabilitation | 45% |
| Research | 20% |
| Teaching | 15% |
| Administration, organisational work, and continuing professional training | 10% |

It would clearly be wrong to assign a precise significance to such proportions, but our impression is that they fairly reflect the relative importance assigned by witnesses generally to the different activities.

**Clinical psychology in relation to different age-groups**

a. *Children and adolescents*

4.15 A general view emerged from the evidence that there was scope for a considerably increased contribution by psychologists in helping this age group. Apart from the work done by psychologists on mental illness and mental handicap, reference was made to the help needed by young people suffering from disabilities such as autism, physical handicap and general learning and behaviour difficulties. Witnesses also commented on the part psychologists could play in vocational guidance and counselling services for adolescents.

4.16 In this connection a number of witnesses commented on the relationship between the work of clinical psychologists and that of educational psychologists. The part played by educational psychologists in the child guidance team was emphasised and it was suggested by some witnesses that the division between educational and clinical psychologists was artificial and tended to obstruct effective working, given the large amount of common ground between them. The view was put forward by these witnesses, who included the British Medical Association and the working party set up by the British Psychological Society to prepare the Society's evidence to us, that a new discipline of child psychology should be established combining the relevant features of both clinical and educational psychology. The opposite view was, however, put forward by a number of other witnesses, including the British Psychological Society's Division of Education and Child Psychology, who felt that the different approaches of clinical and educational psychology each had a valuable and necessary part to play in helping young people.

b. *Adults*

4.17 Witnesses remarked that (as we have already noted) the present work of clinical psychologists was concentrated on the assessment, diagnosis, treatment and rehabilitation of the mentally ill and mentally handicapped. A number of witnesses commented in particular on the current and potential contribution of psychology in the field of mental handicap.

4.18 In relation to mental illness it was suggested that there was a tendency at present for psychologists to concern themselves more with those suffering from neurotic and personality problems than with psychotic patients. New approaches

which had been developed in psychology might have something positive to offer this latter group. The help which psychologists could give in the rehabilitation of long-stay patients was particularly mentioned.

4.19 In addition many suggestions were put forward about the contribution which might be made by psychologists to health care outside the psychiatric field. There was already increasing use of psychological assessment and treatment in relation to reactions to physical illness and to treatment procedures, especially in intensive care units. Psychophysical techniques (concerned with the assessment of sensory functions) could be used to follow the progress of recovery from a wide range of conditions and to help determine the need for further medical intervention; psychologists could do much more to help patients to adjust themselves, for example, to physical handicap, severe head injuries and long-term illnesses. The British Association for Rheumatology and Rehabilitation put forward the view that every rehabilitation department should have a psychologist as a member of the multi-disciplinary team. It was also suggested that psychologists could contribute much to diagnosis and treatment in general medical practice, where patients' physical symptoms are often the expression of undetected neuroses and tensions.

c. *The elderly*

4.20 We were told that the involvement of psychologists in the clinical management of geriatric patients is at present minimal or non-existent. The British Geriatric Association told us that they would welcome more participation by psychologists in this field, in particular in helping to develop a therapeutic milieu in wards and day hospitals and in developing programmes to help elderly people in adjusting to their failing functions.

**Organisation of psychological services**

4.21 There was agreement among many witnesses that psychology should be organised as a unified service on an Area basis. It was felt that this would allow individual psychologists to pursue their particular specialised interests without feeling isolated, would provide a more attractive career structure, and would assist the organisation of training. At the same time some witnesses mentioned the need to balance the requirements of a centralised service against the desirability of close involvement between psychologists and their other professional colleagues at local level. One suggestion was that, while specialised services should be provided from a central Area department of psychology, there should also be psychologists seconded to work in individual units.

4.22 The idea of a comprehensive Area service was criticised by some witnesses concerned with the field of mental handicap. It was argued that the clinical psychologist could make the fullest contribution in this field only by being a permanent part of the individual hospital or unit and deeply involved in local management issues. The British Society for the Study of Mental Subnormality favoured a separate psychological service for the mentally handicapped, co-ordinated by a Top Grade psychologist. Such a service should be freely available to those working in the community.

4.23 There was wide agreement that clinical psychology services should in general be provided from a hospital base, although witnesses also emphasised the need for services to be made available in the community to general practi-

tioners and others, including the staff of local authority social services departments. Although there was a widespread view among those who favoured an independent department of psychology that it should have its own out-patient and day-patient facilities, it was not generally seen as essential for the department to have its own in-patient beds and some witnesses saw positive objections to this, related partly to the question of medical responsibility.

4.24 It was generally agreed that Regional arrangements would be needed to assist co-operation between those in charge of Area services in assessing priorities and making effective use of resources in the Region as a whole. There were some activities, such as multi-centre research projects, for which the Region was the appropriate level of organisation.

4.25 The British Psychological Society advocated the appointment of a psychologist at the Department of Health and Social Security to maintain a national view of the development and requirements of clinical psychology.

**Arrangements for referring patients to psychology services**

4.26 There was general agreement that psychology services should be made freely available within the NHS to all doctors, although witnesses pointed out that the scope for this was inevitably limited at present by the small size of the profession. There was, however, a divergence of view on the question of referrals from non-medical sources. A minority of witnesses argued against patients being referred in this way under any circumstances. Others put forward the opposing view that psychology services should be made freely available without restriction to all professional workers, and that psychologists themselves could reasonably be expected to take the responsibility for recognising a need for medical help and ensuring that it was made available. But the most widely held opinion seemed to be that referrals from non-medical sources were acceptable provided (where the psychologist was working in the National Health Service) the arrangements were agreed with the patient's general practitioner or another doctor responsible for his treatment at the time.

**Clinical responsibility**

4.27 The question of referring patients to psychologists is closely linked with that of clinical responsibility for their treatment. The comments we received on this question reflected perhaps the most marked division of opinion among our witnesses. On one side, there was a strongly held view among many of our medical witnesses that there were no circumstances under which a psychologist should take clinical responsibility for patients. The General Medical Council commented on this that: "Within the NHS, the practice of psychology as a therapeutic procedure by persons other than registered medical practitioners is ultimately the responsibility of the referring general practitioner or consultant. In extreme cases, improper delegation of medical duties to unregistered persons may render a doctor liable to charges of serious professional misconduct." The Hospital Consultants and Specialists Association and the Society of Clinical Psychiatrists were among those emphasising the dangers of diffusion of the responsibility exercised by the medical profession.

4.28 On the other side it was argued that there were some circumstances in which a psychologist might reasonably exercise clinical responsibility, although it was universally agreed that the psychologist must work closely with the

referring doctor. The comments put forward by the British Psychological Society on this point appeared to reflect a fairly widely held view which appeared in different forms in a number of other submissions. The Society said that:

> "It is the responsibility of a referring medical practitioner . . . to assure himself that the clinical psychologist is qualified. Thereafter the psychologist is responsible for whatever acts he carries out in treatment . . .
>
> The clinical psychologist's responsibility covers all acts which are within his competence. As is the case with all independent professionals, it is part of his competence not to exceed the boundaries of his skills. Where a clinical psychologist and a medical practitioner are jointly engaged in the care of an individual, they should establish by agreement their specific areas of responsibility."

4.29 Our own views on this subject are put forward among our recommendations in the next chapter. But it may be worth mentioning at this stage our impression that the difference of opinion on this point arises at least in part from different interpretations being placed on the term "clinical responsibility".

**Personnel**

4.30 One of the questions on which we invited views was the staffing needs for a full psychological service in a District of 200,000–250,000 population. Fewer than half of our witnesses felt able to comment on this. The estimates which were put forward gave a range of between 4 and 8 psychologists for each District, representing a population of between 30,000 and 60,000 for each psychologist. The British Psychological Society suggested that the initial target should be one psychologist to 60,000 population but that there should be a steady further expansion until a ratio of about 1 : 25,000 was achieved. There was no general agreement on the desirable distribution between different grades.

4.31 Most witnesses agreed on the necessity of employing technicians in connection with setting up and maintaining equipment. Some also favoured the employment of technicians to carry out routine testing and assessment and some simple therapeutic procedures, but other witnesses felt there was little scope for technicians to work in these areas.

4.32 Apart from the role of educational psychologists in the assessment and treatment of children (discussed in paragraphs 4.15 and 4.16), witnesses also mentioned the contribution they could make in the assessment and rehabilitation of the physically and mentally handicapped. It was argued that educational psychologists should be involved at any point in the service where their expertise had a part to play, and that there should be close co-operation between health and education authorities to facilitate this.

**Staffing structure**

4.33 There was a general view that the present staffing structure for clinical psychologists was too inflexible and did not provide sufficiently good career prospects, and it was felt that the establishment of area psychological services would help to improve this (see paragraph 4.21). There was criticism in particular of the present restriction of Top Grade appointments. One suggestion was that a Top Grade psychologist should be the head of an Area psychological service, with a Principal responsible for a District service and a Senior Psychologist having a supervisory role over the work of basic grade psychologists. A further

suggestion for which there was considerable support was the creation of a new grade of Senior Principal between the present Principal and Top Grades.

**Training**

4.34 Witnesses criticised the inadequacy of present training facilities and the content of some training courses. Members of the Department of Psychology of the University of Newcastle estimated that at present some 2,000 students were graduating annually from British universities with honours or joint honours in psychology, and that about 40% of these would be both suitable for a career in clinical psychology and sufficiently interested to apply for a postgraduate training place. The present training facilities were, however, adequate for only a tenth of this number. There was widespread support for expansion of the facilities and the British Psychological Society suggested that this should be the subject of an urgent enquiry by the Department of Health and Social Security.

4.35 Members of the Institute of Psychiatry mentioned that existing courses were not always filled because of uncertainty about how students were to be financed. Both the Institute and a number of other witnesses favoured a system of central funding.

4.36 As to the content of training courses, there was a general view that more emphasis was needed on therapy, community health and general counselling, physical illness and work with the disabled and elderly. A range of courses was needed to cater for different interests and specialties, and there should also be increased facilities for post-experience training. It was essential to have a mixture of academic and practical training and it was widely felt that purely in-service training not leading to a diploma should cease to be recognised as a qualification for work in the National Health Service.

**Teaching of other professions**

4.37 It was generally felt that psychologists had a great deal to contribute to the teaching of other professions, including doctors, nurses and social workers, both at basic level and as part of in-service training.

**Research**

4.38 Virtually all witnesses agreed in seeing research as a field in which psychologists had a particularly important contribution to make. Indeed research was an essential part of their work and it was partly by a continuing process of critical evaluation of the work of their own and other professions that they were able to contribute to the advancement of health services. This was an interdisciplinary activity in which psychologists must participate with the other professions concerned. Among research fields seen by witnesses as specially significant were the attitudes of patients and staff, and the value and cost-effectiveness of widely used psychological procedures. It was suggested that to make the best use of resources, research should be organised on an Area basis. Witnesses also emphasised the importance of co-operation in research between the National Health Service and University Departments of Psychology.

# 5. THE SUB-COMMITTEE'S PROPOSALS

## 5.1 General

5.1.1 On many issues the evidence we received showed that there was a wide consensus of views, and with this we have found ourselves very largely in agreement. In particular we agree with our witnesses that there is scope for a greatly increased contribution by psychologists in many fields of health care, and that their growing involvement in the direct provision of therapy, as distinct from the more traditional activities of testing and assessment, is of special significance. However, the fact that so many fields are involved itself presents problems. In most of them, with partial exception of mental illness and mental handicap, participation by clinical psychologists is at present very restricted. A psychological service cannot be established in all these areas at once, and if the service is to be developed in an orderly way it is essential that there should be some means of determining priorities. Unfortunately there does not exist an objective basis for weighing the needs of different clinical fields against each other so as to give an order of priorities for the National Health Service as a whole; too much depends on local factors and the special characteristics of particular areas. In the absence of a general order of priorities it is necessary to ensure the adequacy of arrangements for determining priorities at local level.

5.1.2 At the same time we have to recognise the realities of a time of economic difficulty in which resources are insufficient to sustain the desirable level of development across the whole range of the health and personal social services. We felt it incumbent on us, in formulating our proposals, to take account of the need to help the service through these (as we hope) relatively short-term difficulties, while at the same time looking forward to the longer-term expansion which we are convinced is desirable.

5.1.3 It seemed to us therefore that we should concentrate on suggesting a pattern of services which would both ensure the best use of resources of money and manpower and provide a framework for what at first would inevitably be a gradual expansion. The key issues, as we saw them, were those involved firstly in the relationship between psychologists and the members of other professions—especially the medical profession—and secondly, in the organisational pattern of psychology services. Both these issues gave rise to a great deal of comment in the evidence we received. Closely related are the questions of manpower, of the career structure for psychologists, of training and of research.

5.1.4 We have recorded in the previous chapter the views we received on a very wide range of issues, of which those just mentioned form only a part. It has not been possible for us as a Sub-Committee to form a definite judgment of all the questions which were raised. To do justice to some of them would have required a depth of consideration which our resources as a group, and the constraints of time, did not permit. Also it would be unrealistic to try to establish a definite blueprint for the future of a service which, though its importance and potential are established beyond doubt, is in some respects only at an embryonic stage of development. There are some lessons which can only be learnt from practical experience as the service develops and a fuller realisation of its powers is achieved. We hope, however, that our review of the evidence will have some value in itself as an attempt to convey the range of opinions held among a very

wide cross-section of those concerned with the future development of this service.

5.1.5 We were anxious that any recommendations we made should command as wide as possible a degree of acceptance among those likely to be affected by them. Having agreed among ourselves on an initial statement of our views, we decided that before putting these forward as definite recommendations we should invite comments on our proposals from the major organisations who had responded to our request for evidence. We therefore sent the statement of our proposals to these organisations (listed in Appendix C) in February 1974, in the form of a consultation document. This document, with such modifications as we thought it right to make in the light of comments we received, forms the basis of our recommendations in the following paragraphs. We need hardly add, though, that the recommendations are ours alone and that it would be quite wrong to see the informal process of consultation which we undertook as implying any sort of commitment on the part of those it involved.

## 5.2 Psychology in a Health Service context

5.2.1 We have described what we see as a steadily expanding role for psychologists in the provision of health care. While the general character of this role will, as we hope, be reasonably clear from our summary of the evidence we received and our own comments on it, this is not something on which it is possible to make any definitive statement. Like that of any other profession, the role of psychologists is continually evolving. Our concern has been to identify as far as we can the kind of working relationship between psychology and other professions, and the pattern of organisation, which will most help psychologists in making an effective contribution to the National Health Service generally.

5.2.2 We think this requires, firstly, that the professional status of clinical psychologists in the National Health Service should be fully recognised and should be reflected in the organisation of their services. Thus psychology should not be regarded as an adjunct of any other profession and psychologists should be recognised as constituting a responsible group having specific skills to contribute to patient care in co-operation with the other professional groups concerned.

5.2.3 At the same time the work of any group involved in the care of patients has to be considered in relation to the patients' needs as a whole. We have recorded the extensive discussion in the evidence submitted to us of the question of "clinical responsibility". The terms in which we raised this question did not, perhaps, take sufficiently into account the special medical and legal significance of the concept of clinical responsibility, and the broad concern it implies with a patient's well-being. We fully recognise that, for any patient under treatment in the National Health Service, there is a continuing medical responsibility which cannot be handed over to any other profession. If psychologists are to be seen as having an independent professional status, it is essential to consider how this relates to the principle of medical responsibility which is exercised by the medical profession alone.

5.2.4 It seems to us that the only way in which these two principles can be reconciled is through multidisciplinary teamwork. We are aware that this is a growing practice and obviously generalisations about it should be put forward

only with caution. But as we understand it multidisciplinary teamwork implies the mutual recognition, by the members of the different professions concerned, of a shared responsibility for patient care. This does not, we must emphasise, mean that every decision affecting a patient will necessarily be a team decision. Each profession has its own sphere of competence and its members are responsible for their decisions within that sphere. They are also individually responsible for recognising the limits of their own competence and enlisting the involvement of their colleagues when this becomes necessary. The decisions which involve the team as a whole are those concerning the patient's care as a whole which involve a choice between different forms of professional intervention.

5.2.5 There is thus a distinction between independent professional status, as we have defined it, and full clinical responsibility which in the National Health Service can be exercised only by certain medical practitioners (consultants and general practitioners, depending on whether or not the patient is receiving hospital treatment). Professional independence within a team setting clearly does not imply an absolute handover of responsibility for the patient from one member of the team to another. It will, of course, be natural to regard the psychologist as the expert within the team on the appropriateness of using psychological assessments or procedures. Equally, if a need is identified for a particular procedure or programme which the psychologist is best equipped to apply, it seems to us right that he should be recognised as carrying responsibility, within such limits as may be agreed with other members of the team, for that aspect of the patient's treatment and care. There should be no question, therefore, of the patient's medical interests being jeopardised. A decision to use a psychological technique or procedure will not, in these terms, be taken without reference to the patient's overall interests and to the need for medical forms of intervention either concurrently or as an alternative.

## 5.3 Organisation of services

5.3.1 We have said that, while psychologists undoubtedly have an increasing part to play in the provision of health care generally, the future development of their role is not something which can be predicted with any certainty. Our concern in considering how their services should be organised has been to suggest a structure which, while reflecting the wide range of their potential involvement, will have sufficient flexibility to allow for the different ways in which their role may develop.

5.3.2 Trained clinical psychologists are a scarce resource. In the face of competing claims for their services it is essential that development should be properly controlled, and in our view this calls for the establishment of a distinct organisation, in which there is a defined point of responsibility for considering priorities as between different fields of work. Moreover a profession which is at the same time small and scattered needs some organisational coherence if its members are not to become isolated. However, the day-to-day work of health service psychologists takes place, as we have indicated, largely in the context of multidisciplinary teams concerned with particular clinical fields. At present the great majority of the profession is concerned with the fields of mental illness and mental handicap. The specialties in relation to which we have received evidence of a potentially greater psychological contribution include, most notably, physical handicap, child and adolescent health problems, neurology and neuro-

surgery, general medicine, geriatrics, and community medicine, as well as the field of general medical practice. A close working relationship is needed between psychologists and others working in this wide range of medical specialties and other professions. The danger of a comprehensive department of psychology becoming remote from the operational needs of the service, will only be obviated if lines of responsibility are drawn up so as not to conflict with the responsibilities of psychologists to their colleagues in the multidisciplinary teams.

5.3.3 We have also thought it right to consider where in the new National Health Service structure clinical psychology services should be organised. For the majority of the health services with which psychology is associated the focus will be in the District and there would be obvious advantages if psychology could fit into this general pattern. Unfortunately the relatively small size of the profession for the time being rules this out as a general solution. The number of National Health Service Districts in England and Wales is 218 while, at the latest date for which figures are available, there were only 585* clinical psychologists employed in the service as a whole. We have therefore concluded that for the foreseeable future it is on an Area basis that psychology services will need to be organised. In single District Areas the two organisations will of course be identical and in addition we see scope for some flexibility even in Areas with more than one District.

5.3.4 To describe the organisation we propose, we use for convenience the term "Area department of clinical psychology". The first priority for such a department, given the present scarcity of numbers, should we think be the continuing development of an adequate service in fields—notably mental illness and mental handicap—where the profession is already relatively well established. But if the numbers of psychologists increase steadily—as we think they should—there will be scope for the department to expand into the other fields we have mentioned. In this situation we envisage that the Area department would be subdivided into a number of specialist sections corresponding to the different clinical fields (or groups of related fields) in which psychologists are working. One of the psychologists in each specialist section would have overall responsibility, under the head of the department, for the general development in the Area of his specialised element of the clinical psychology service. Ideally the head of each of these sections would be a psychologist of at least Principal level. Although this will not always be practicable in present circumstances, it is nevertheless important that junior psychologists should not have to work in isolation and in our view a psychology service should not be developed in any field unless a psychologist of at least Senior Grade is able to take charge of it. In a fully developed Area department the specialist groupings of psychologists might be on something like the following pattern:

1. *Physical Handicap:* working in close liaison with Occupational and Educational Psychologists
2. *Mental Handicap:* working in close liaison with Occupational and Educational Psychologists
3. *Child Health:* (Child Psychiatry and Paediatrics) working in close liaison with Educational Psychologists
4. *Neurological Sciences:* (Neurology and Neurosurgery)

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* Whole-time equivalent figure.

5. *Mental Illness:* (including Forensic Psychiatry and Psychotherapy)
6. *Geriatrics*
7. *Adolescent Services:* working in close liaison with Educational and Occupational Psychologists
8. *Primary Health Care:* (also working with Community Physicians on the development of preventive services)

The above is only one possible pattern, and we would emphasise the need for flexibility and for local arrangements to take account of local needs. It will be for Regional and Area Health Authorities to determine the priorities as between different fields of work. Provision of psychology services in fields other than those we have listed would need to be determined in the light of local circumstances.

5.3.5 The establishment of a comprehensive range of psychology services should in our view be concentrated initially in teaching Areas, or other Areas with a well-established service, where the maximum contribution can be made to teaching and research in the interests of the service as a whole. It is important, however, that this should be seen as providing a model for a more widespread development of services and not as a permanent concentration of resources.

5.3.6 The psychologist at the head of the Area department would have the major responsibility for its overall co-ordination and development and we would expect him to be regarded as the spokesman for clinical psychologists in the Area. His duty should not, however, become predominantly administrative and it would be essential in our view for him to continue his professional practice, combining the duties of head of department with work in one or other specialised field. He would be administratively responsible to the Area Team of Officers and would need to co-operate with the Area Medical Officer in the co-ordination of clinical psychology services within the Area. The Area Administrator should be expected to provide the supporting services required for the organisation of the department. The head of the department would clearly be the key figure in the general development of clinical psychology services. However, it follows from what we have said about the professional standing of clinical psychologists, and their place in multidisciplinary teamwork, that we would not expect those in the grade of Principal Psychologist to have to account to the head of the department on matters of purely professional judgment. Below Principal level, however, we consider that all clinical psychologists should be directly accountable to a professional superior.

5.3.7 A structure of this kind should foster the close working relationship which is needed between psychologists and their colleagues in other health service disciplines. But at the same time the existence of a department with broad responsibility for psychology services should encourage a wide exchange of ideas between psychologists working in different fields, should assist their deployment in accordance with agreed overall priorities within the Area, and should ensure the availability of a varied range of training and career experience.

5.3.8 The work of clinical psychologists takes place, of course, in a variety of locations. Many are at present based in mental handicap or mental illness hospitals. Clearly in a structure such as we propose it would be natural for arrangements of this kind to continue. But we think there should also be a

defined base for the Area department, preferably associated with a district general hospital. Some of the accommodation might be shared with an existing academic medical department or postgraduate institute. The existence of this base should facilitate liaison with other psychologists such as educational and occupational psychologists, and members of the Prison Psychological Service, who are not of course members of the Area clinical psychology department. It should serve as a meeting place for all concerned, including clinically trained research psychologists working in the health services. The existence of the department may provide scope for some centralisation of psychological laboratory facilities where appropriate.

5.3.9 The development of local authority social services departments and of the services they provide for disadvantaged groups in the community carries with it an increasing need for psychological advice, particularly in relation to the setting up and running of homes, hostels and day centres. Although in some instances local authorities will no doubt look to their own educational or other psychologists to provide this, the clinical psychologist will also often be able to help. Section 11 of the National Health Service Reorganisation Act 1973 provides for the services of health service professions to be made available to local authorities, and with Area services the provision of such psychological advice to social services and education departments should not be difficult to arrange. Co-ordination of the necessary arrangements might be a specific responsibility of the head of one of the specialised groups of psychologists.

5.3.10 It is important that the views of clinical psychologists as a profession should be taken fully into account in the planning and operation of Area services. We have referred to the role of the head of the Area department as spokesman for the profession; we do not think, however, that this obviates the need for more formal advisory arrangements. To this end we recommend that Area Psychological Advisory Committees should be established in all Areas where the service is sufficiently developed to justify them. Such Committees would provide a means of participation for the clinical psychology profession as a whole. Their value would be greatly increased if in addition they included representatives of other psychologists, particularly educational psychologists, working in the Area. Consideration should be given to the recognition of Area Advisory Committees by the Secretary of State under Section 8(2) of the National Health Service Reorganisation Act 1973.*

5.3.11 Although we have recommended that the Area should be the main focus of the psychology department, we think that in Areas with more than one District there would be advantage in having a degree of less formal co-ordination

* Under Section 8(1) of the 1973 Act separate advisory committees may be set up in each Region and Area, each representative of the medical practitioners, the dental practitioners, the nurses and midwives, the pharmacists, and the ophthalmic and dispensing opticians of the Region or Area. The Secretary of State has a duty to recognise these committees if he is satisfied that they are representative of the categories of persons concerned. Section 8(1) does not provide for the recognition of committees representative of any other categories of persons mentioned above. Section 8(2), however, lays a duty on the Secretary of State to recognise, in a similar way, advisory committees representative of other categories of persons who provide services forming part of the health services, or to recognise a single committee as representative of two or more of any of the categories concerned, where he is satisfied that it is in the interests of the health service to do so. So far no committees have been recognised under Section 8(2) and the Secretary of State has announced (Hansard, 21 February 1977, vol. 926, col. 449) that he does not intend to recognise any such committees at the present time.

on a District basis; possibly a psychologist of senior standing in the District could be given specific responsibility for this. Representatives of local clinical psychologists could be invited to attend meetings of Cogwheel Divisions, in particular the Divisions of Psychiatry, Medicine and Child Health. While this would be a useful form of interdisciplinary co-operation, the scale of such arrangements would necessarily depend very much on the overall level of manpower and its deployment, and the geographical characteristics of the Area. It is also important that psychologists should have a place on those health care planning teams to which they can make a contribution.

5.3.12 The pattern of organisation proposed here is the one which seems to us best on balance given present circumstances and present needs—though, as we have pointed out, we would hope to see it applied flexibly with due account taken of local variations. As the service develops and expands, the scope for alternative arrangements may well increase, and we envisage that some Areas, in which the service develops relatively quickly, will soon be able to move towards full District service. Indeed a longer-term possibility is that all clinical psychology services might be organised on a District basis and this would have obvious advantages from the point of view of integration with other local health services. We do not think, however, that on any realistic view of future levels of manpower this is likely to be a viable development, at any rate within the next 20 years.

5.3.13 The possibility of increased participation by psychologists with general practitioners in the primary care setting involves a number of special factors. The other fields we have mentioned are essentially hospital-based and there may be problems in the relationship between a mainly hospital-based profession and a group working in a different setting. Meanwhile we would suggest that pilot studies with built-in full evaluations should be mounted of referrals from general practitioners to National Health Service clinical psychologists. We appreciate also that authorities may be reluctant to undertake a new departure at a time when not all established priorities can be satisfied. Nevertheless we see the future role of psychologists in community-based work as an important one in which they may well be able to make a significant contribution to the prevention of some illnesses and to primary care in the case of others, and we hope there will be some development along this line in the reasonably near future.

## 5.4 Referral of patients

5.4.1 We have already discussed at some length the nature of the relationship between psychologists and the medical profession, and the existence of an ongoing medical responsibility for any patient who is receiving a psychological service. Referral from sources outside the health service into health care will necessarily involve appropriate medical screening (normally by the patient's general practitioner). Cross-referrals by clinical psychologists within the health service to educational psychologists and others working outside the health service will need to be made in consultation with medical colleagues. Such arrangements would not affect the direct referrals between general practitioners and clinical and educational psychologists which we would expect to take place in the future as they do now (we refer in paragraph 5.13.3 to the general question of cooperation between clinical and educational psychologists).

5.4.2 It has been suggested in some of the evidence submitted to us that, given the degree of responsibility which clinical psychologists may exercise in relation to the care of patients, they should be required as a condition of their National Health Service contract to take out indemnity insurance, as many at present do of their own accord. We have been advised that, in the event of a successful claim against a health authority on the grounds of negligence on the part of a psychologist, the authority is in theory entitled to seek a contribution from him. In practice, however, the policy of the Department of Health and Social Security is that an authority should not seek a contribution from its professional staff other than medical practitioners. Any modification of this practice for clinical psychologists would inevitably have implications for other health professions which we are not in a position to assess. We hope, however, that the arguments which have been put forward on this point will be further considered by the Department. It is, of course, for the individual psychologist to consider the need for insurance against claims which might arise from private practice.

## 5.5 Regional functions

5.5.1 Given the present scarcity of manpower we think there is a place for psychological advice to be available on a Regional basis and for Regional Health Authorities (and the Welsh Office in Wales) to play some part in assessing priorities for the Region as a whole, and we agree with the view which has been put to us that a Regional Psychological Advisory Committee should be established for each Region and for Wales. Such a committee would also be in a position to advise on the setting up of any specialised psychological services which would cut across Area boundaries. It would, in addition, be able to advise on questions of training; this is clearly one of the keys to the future development of the service and we discuss in paragraph 5.9.1 below the part which we see the Region playing. Consideration should be given to the recognition of Regional Advisory Committees under Section 8(2) of the National Health Service Reorganisation Act.

5.5.2 Apart from its general concern with the overall development and planning of the service, we think the Regional Health Authority, by means of a professional committee, should play a specific part in the selection of psychologists to fill posts graded Principal Psychologist and above, and we recommend that the Whitley Council should be invited to consider this proposal.

## 5.6 National advice

5.6.1 We think there is a need for a recognised channel of communication whereby the views of psychologists on matters affecting the National Health Service as a whole can be made known to the Department of Health and Social Security and the Welsh Office, and we suggest that the Departments should consider how this can best be arranged within the framework of the advisory machinery being developed for the National Health Service as a whole. We are glad to note in this connection the recent appointment of a Consultant Adviser to the Department of Health and Social Security on clinical psychology services. We think that the Department should in addition appoint centrally a full-time psychologist with responsibilities for the development of the service nationally.

## 5.7 Manpower

5.7.1 The proposals we have made reflect our conviction that clinical psychology has an increasing contribution to make in a wide range of health services. Such an aim clearly implies a substantial increase in the number of clinical psychologists employed in the National Health Service.

5.7.2 We recognise, of course, that the consideration of manpower levels involves a much wider range of questions than we have been able to examine, and that in the present economic climate it may not be possible to make firm plans related to a particular rate of expansion. Our suggested structure of services is, we hope, flexible enough to make good use of the available manpower whether expansion is rapid or more gradual. We have referred in paragraph 4.30 to the estimates of manpower requirements which were put forward in the evidence we received, giving a ratio of one clinical psychologist to between 30,000 and 60,000 population. This represents an approximate range of 830 to 1,660 clinical psychologists for England and Wales. A ratio of one psychologist to 25,000 population (which was suggested by the British Psychological Society as a long-term target) would represent a total of about 2,000 clinical psychologists. The number in post on 30 September 1973 was, it will be remembered, only 585.

5.7.3 At the higher end, therefore, the estimates which were made imply a very large increase relative to the present staffing levels. The case for such an increase is, we have no doubt, a very strong one. We have depicted in this report the very wide area in which clinical psychologists have a contribution to make. Almost all their present work takes place in the fields of mental illness and mental handicap; nevertheless the present numbers are widely felt to be inadequate in relation to the needs of these groups. Substantial expansion is clearly needed to provide a satisfactory service even in this limited area, quite apart from the needs of new groups of patients.

5.7.4 It would, however, be unrealistic for us in the absence of a detailed study of the question to suggest precise long-term manpower targets or a precise timescale for achieving them. There is a clear need for such targets to be developed—not least so that decisions can be taken on the level of training facilities—and we think that a full study of manpower needs should be undertaken as soon as possible by the Department of Health and Social Security. We should like to urge on the Department the definite need, as we see it, for a substantial expansion in numbers, and we hope that the various targets quoted above will be carefully considered.

5.7.5 Even with existing training facilities, and those now planned, it should, we think, be possible to sustain an annual increase of about 80 in the number of clinical psychologists employed in the service (see paragraph 5.9.4). On this basis the total might rise to about 1,100—nearly double the present number—within a period of six or seven years. This should, we think, be regarded as a minimum target for the shorter-term.

5.7.6 Careful thought will need to be given to the order of priorities as between different clinical fields. The greatest unmet needs seem to us to lie in the fields of child psychiatry and mental handicap, and we hope that these will be given particular attention. In numerical terms the most important group (because there are so many patients involved) will undoubtedly continue to be mentally ill adults. It is important that a balance should be struck between their needs and

those of mentally ill children and the mentally handicapped, while at the same time leaving some margin for developing a service in the other, relatively unexplored fields which we have mentioned in paragraph 5.3.4. In relation to mental handicap, particularly, it is possible that new patterns of care will involve a greatly increased need for psychology staffing.

5.7.7 Apart from psychology manpower requirements as such, we have given thought to the question of supporting staff. Equipment used by clinical psychologists has obviously to be serviced and maintained; this job can probably be done as part of the work of physics technicians, or in some other way depending on local circumstances, and we do not see this as presenting special problems. But there is also a good deal of work in clinical psychology, such as some aspects of assessment, measurement, recording and treatment, which, while calling for intelligence and skill, can reasonably be delegated by psychologists to a less highly qualified group. Psychological technicians are probably best suited to undertake this kind of work. (We are aware that at present functions of psychological technicians are sometimes performed by nursing staff attached to a psychology department; this is not a satisfactory arrangement because the hospital's nursing needs inevitably take priority.)

## 5.8 Career structure

5.8.1 We have emphasised the importance of the co-ordinating responsibilities which would be exercised by the head of an Area Department and we would clearly expect these to be reflected in the grading awarded to such posts. A number of witnesses have argued that the present career structure offers too little scope for advancement, that a new grade of Senior Principal should be established between the present Principal and Top grades. It seems to us that there is a need for some form of recognition of work of particular merit at a number of levels above that of Principal and that the Whitley Council should be asked to consider the desirability of establishing a Senior Principal grade. We think it important, also, that psychologists should have the opportunity of attaining Top grade or similar status on the grounds of outstanding work in a specialised field as well as on grounds of co-ordinating responsibility.

## 5.9 Training

5.9.1 In view of the importance of training to the future development of the service we think that its overall organisation should be a responsibility of the Regional Health Authority (and the Welsh Office in Wales) which would be advised for this purpose by a training sub-committee of the Regional Advisory Committee recommended in paragraph 5.5.1 above. We agree with the view put to us by the British Psychological Society and others that there might be merit in the appointment of a regional tutor responsible for arranging placements for trainee psychologists, in consultation with the heads of university-based courses and with individual Area departments of psychology. A psychologist appointed to such a post would need to have sufficient time allocated for the purpose of discharging these duties.

5.9.2 We also agree with the view which has been expressed by several witnesses that all clinical psychologists should in future be required to obtain either a recognised postgraduate degree or the BPS Diploma in Clinical Psychology.

This would bring to an end the present arrangements under which some psychologists undergo in-service training not leading to a formal qualification. Given the present level of training facilities we do not anticipate that this will produce any insuperable difficulties in staffing the service. The organisation of psychologists in an Area department should also eliminate the possibility of trainee psychologists spending the whole of their three years probation in one hospital under one Senior. It should generally be possible to provide sufficient placements within an Area to enable students to obtain the variety of experience needed for the Diploma or a higher degree, although places in adjoining Areas could of course be used if necessary.

5.9.3 At present, clearly, the availability of training course places is a limiting factor in the expansion of clinical psychology services. We understand that there is a substantial supply of graduates with first and upper second class honours in psychology, and that the number of candidates for training courses greatly exceeds the number of places available. Plainly there is considerable scope for expansion of training facilities, and this we strongly support provided the pace is not such as to risk any dilution of the present high standards. We are glad to note that a number of regions at present without formal training schemes are now developing them. More places are also needed on university-based courses. It is, however, our view that the emphasis for the present should be on expanding existing university courses, at the same time giving them a broader geographical basis by using training facilities in more Areas, rather than on establishing entirely new courses.

5.9.4 Taking existing courses with those now in the planning stage, it seems that the output of qualified psychologists when the planned courses are fully developed could be of the order of 150 annually, and allowing for wastage and for numbers leaving the profession this might be enough to sustain the overall annual increase of some 80 which we have mentioned above. To maintain growth in future years would, of course, require a further progressive expansion of training facilities. The availability of senior psychologists who can undertake in-service training will, of course, be a limiting factor on the expansion of services which will have to be taken into account in considering the level of training facilities.

5.9.5 The development of Area departments should make it possible to provide all staff with the opportunity of attending refresher courses and conferences, without detriment to the service's needs. In addition a few psychologists—possibly at Senior grade—may benefit from a longer period of secondment to a unit which could provide very specialised training; eg some forms of behaviour therapy or psychotherapy. A few special units in England and Wales might be given one or two rotating posts to meet these advance training needs.

5.9.6 Our remit does not extend to consideration of the financing of training courses. We have referred above to the view expressed in evidence to us that the present method of financing tends to inhibit Regions from sponsoring trainees, and we hope that this matter will be further considered by the Department of Health and Social Security.

## 5.10 Research

5.10.1 The contribution of psychologists to research is an important one, often extending beyond the profession's own immediate fields of work. There should

be opportunity for all psychologists working in the service to undertake research appropriate to their interests. The scheme proposed in the Report of the Working Party on the Decentralised Clinical Research Scheme in England and Wales will, we hope, provide adequate opportunities for this. It is often valuable for a full-time research psychologist to work as part of the clinical team appropriate to the context of his research. Some such posts might be university appointments while others might be funded by Research Councils or Health Authorities. To maintain high standards, and avoid intellectual isolation, there should be strong working links between all those undertaking research, whatever their affiliation.

## 5.11 Training of other professions

5.11.1 We have received clear evidence of the contribution psychologists can make to the training of members of other professions in the health and social services, and full account should be taken of this in the overall running of an Area service. It is important that such training should be, and be seen as, relevant to the work of those to whom it is given, and that psychologists should work closely with others responsible for training. Psychology training should thus form an integral part of Area and Regional training programmes, making full use of centrally provided resources.

## 5.12 Mental handicap

5.12.1 We have recommended that psychologists working in the field of mental handicap should, along with their colleagues in other sections of the service, form part of the Area-based department of psychology. We recognise that the contribution of psychologists in this field has in many ways developed its own distinctive characteristics, and we appreciate the force of the case which some of our witnesses have put forward for a separate psychological service for the mentally handicapped. Nevertheless we think that on balance the interests of this group will be best served if psychologists working with them can come together with their colleagues in a comprehensive Area service and can benefit from the exchange of ideas which this should afford. We do not think that this should work in any way to the detriment of the service for the mentally handicapped. The establishment of a Principal post concerned exclusively with mental handicap, and the opportunity of reaching still higher posts without leaving this field, should ensure that career opportunities are satisfactory for those psychologists who have devoted themselves to the problems of mental handicap and wish to continue doing so. At the same time opportunities for cross-posting should enable mental handicap to benefit from a continuing inflow of new talent, and should enhance the range of career opportunities for those psychologists working with the mentally handicapped whose commitment to this particular service is less exclusive.

5.12.2 The general tendency of the last few years has been to increase the role of community services in the care of the mentally handicapped and it is likely that development will be increasingly concentrated in the special education, training and social services provided by local authorities. There is likely therefore to be a changing role for specialised health services for the mentally handicapped, so that in the long term these developments may require a change in the orientation of psychological services towards work in a community setting.

## 5.13 Services for children

5.13.1 Our enquiries appear to have prompted a good deal of debate, within the psychology profession and elsewhere, about the kind of psychology services needed for children. We have also had the opinion of the Court Committee on Child Health Services.* Our primary interest lies with psychologists who have received a clinical training and are employed in a clinical setting, usually a hospital. However, the need for psychological help among children and their families far exceeds what could be provided from the resources of the National Health Service. In addition, those who are professionally involved with children and adolescents, such as teachers and social workers, may from time to time need ready access to a psychologist for advice and assistance and the normal practice has been for them to seek this from educational psychologists. It has been suggested to us by a number of witnesses that there could be advantage in establishing a new discipline of child psychology which would combine some of the existing attributes of the disciplines of clinical and educational psychology.

5.13.2 The development of these two separate disciplines within psychology is historical in origin and we have received evidence which argues that the continued distinction is artificial. Many educational psychologists believe, however, that their role demands an understanding of the school and classroom situation which can only be gained from practical teaching experience. It is also clear that educational psychologists will in future spend more time working in schools and other places where children, including those of pre-school age, gather together, and less time than at present in clinics. They will thus be involved increasingly with children generally, as well as with those who have educational or emotional difficulties, and with their teachers and families in an advisory and preventive role. In our view it is important that there should be no intervention by a clinical psychologist in a school situation without the knowledge and consent of the educational psychologist.

5.13.3 On the evidence submitted to us we do not think that a decisive case has been established either way on the desirability of a new discipline of child psychology; this seems to us to be a matter to which the profession itself will need to give further thought. We are however convinced of the need for much closer liaison than at present between the health and education services to ensure the availability of a comprehensive psychology service for all children who can benefit from it. It is important that both clinical and educational psychologists should fully understand the different expertise peculiar to each discipline and should be ready to accept that there has to be some overlapping of function. This will be apparent most clearly in work with pre-school children, with the mentally handicapped and in assessment centres where all handicapped children should now receive comprehensive assessment. We think it necessary that professional skills, knowledge of individual children and familiarity with local conditions should be shared. Essentially, this professional liaison depends on co-operation at the individual level; however, administrative arrangements for the work of both clinical and educational psychologists should be such that co-operation is encouraged and facilitated. This would be assisted if a representative of the local authority's educational psychologists were to be involved

* Appointed in 1973 by the Secretaries of State for Social Services, for Education and Science, and for Wales, under the chairmanship of Professor Donald Court, to review the provision made for health services for children up to and through school life; to study the use made of these services by children and their parents; and to make recommendations. (Cmnd. 6684).

in any type of psychological advisory machinery established under our proposals in paragraph 5.3.10; consideration should also be given to the desirability of seeking contributions from educational psychologists to the appropriate health care planning teams. Arrangements on these lines would of course need to be agreed between health and education authorities. It is important also that general practitioners, school doctors and social workers who are involved with children should have close links with both clinical and educational psychologists and should be alert to the needs of children for help from either source.

## 5.14 Psychologists in non-clinical roles

5.14.1 Clinical and educational psychologists (and to some extent occupational psychologists) will often have a shared interest in the care of individual patients and we have therefore given considerable attention to the liaison which is required. In Chapter 4 of our Report we mentioned the evidence submitted to us of the contribution to be made to the National Health Service by those psychologists who are not directly concerned with individual patients. These would not normally, we imagine, be members of an Area psychology department or have any direct responsibility to its head, but we would expect them to use the Area department premises as a place for meeting and exchanging ideas with clinical psychologists. We have not, however, attempted to form any view on the role of those psychologists who are not involved in patient care. Much of their work is concerned with problems common to large organisations such as the National Health Service. The examination of these activities (if it were thought desirable) would fall to a body differently constituted from ours.

# 6. SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

A. **Scope of clinical psychology**

1. Clinical psychologists have a contribution to make in many fields of health care. Their present role tends to be, in contrast, very restricted, partly because of the small size of the profession. (Para 5.1.1).

2. The major fields, or potential fields, for clinical psychology are mental illness, mental handicap, physical handicap, child and adolescent health problems, neurology, general medicine, geriatrics, community medicine and general medical practice. (Para 5.3.2).

3. Clinical psychologists in the National Health Service should be recognised as having full professional status. (Para 5.2.2). However, we fully recognise that, for any patient under treatment in the National Health Service, there is a continuing medical responsibility which cannot be handed over to any other profession. (Para 5.2.3).

4. Relations between psychologists and the members of other health service professions should be based on multidisciplinary teamwork. (Para 5.2.4).

B. **Organisation of services**

5. In present circumstances it is appropriate for clinical psychology services to

be organised on an Area basis. (Para 5.3.3). In the longer term there may be scope for moving towards a District-based service. (Para 5.3.12).

6. An Area department of clinical psychology should comprise a number of specialist sections corresponding to different fields of work. The head of each section would preferably be of at least Principal grade; in no circumstances should he be below Senior grade. (Para 5.3.4).

7. The comprehensive service we propose should be established initially in teaching Area or other Areas with a well-established service. Such Areas should seek to provide a model for more widespread development. (Para 5.3.5).

8. The psychologist at the head of the Area department should be responsible for its overall co-ordination and development, but members of the department should not have to account to him on matters of purely professional judgment. (Para 5.3.6).

9. Although psychologists will continue to work in a variety of settings, an Area department should also have a defined base of its own, preferably associated with a district general hospital. (Para 5.3.8).

10. The advice of clinical psychologists should be made available as necessary to local authority social services and education departments. (Para 5.3.9).

11. Area Psychological Advisory Committees should be established, and consideration should be given to their recognition by the Secretary of State under Section 8(2) of the National Health Service Reorganisation Act. (Para 5.3.10).

12. There should be informal arrangements for co-ordinating clinical psychology services on a District basis in multi-District Areas. (Para 5.3.11).

13. It is desirable that clinical psychologists should become more closely involved in the primary care setting with general practitioners. (Para 5.3.13).

C. **Referral of patients**

14. Arrangements for cross-referrals with other psychologists should be agreed by clinical psychologists with their medical colleagues. (Para 5.4.1).

D. **Regional functions**

15. A Regional Psychological Advisory Committee should be established for each Region and for Wales. Consideration should be given to the recognition of these Committees by the Secretaries of State under Section 8(2) of the National Health Service Reorganisation Act. (Para 5.5.1).

16. Regional Health Authorities should participate in selection for posts graded Principal Psychologist and above. (Para 5.5.2).

E. **National advice**

17. The Department of Health and Social Security should appoint centrally a full-time psychologist with responsibilities for the development of the service nationally. (Para 5.6.1).

F. **Manpower**

18. Because there is a strong case for increasing very substantially the number of clinical psychologists, (Para 5.7.3), a full study of manpower needs should be

undertaken as soon as possible by the Department of Health and Social Security. (Para 5.7.4).

19. Existing and planned training facilities should be able to sustain an annual increase of about 80 clinical psychologists in the shorter term. On this basis the total number might rise to about 1,100 within six or seven years and this should be regarded as a minimum target. (Para 5.7.5).

20. The greatest unmet needs for clinical psychology services are in our view in the fields of child psychiatry and mental handicap. (Para 5.7.6).

21. Clinical psychologists should be supported in their work by psychological technicians. (Para 5.7.7).

G. **Career structure**

22. The Whitley Council should consider establishing a new grade of Senior Principal Psychologist between the present Principal and Top Grades. (Para 5.8.1).

H. **Training**

23. The overall organisation of training should be a responsibility of the Regional Health Authority (and the Welsh Office in Wales). Each Regional Psychological Advisory Committee should have a training sub-committee. (Para 5.9.1).

24. All clinical psychologists should in future be required to obtain either a recognised postgraduate degree or the BPS Diploma in Clinical Psychology. (Para 5.9.2).

25. It appears to us to be desirable that the primary means of increasing training facilities should for the present be the expansion of existing university courses rather than the creation of entirely new ones. (Para 5.9.3).

26. The Department should consider the case for a new method of financing training courses. (Para 5.9.6).

J. **Research**

27. All psychologists should have opportunities to undertake research relevant to their field of interest. (Para 5.10.1).

K. **Training of other professions**

28. Psychologists have an important part to play in the training of other professions. This should be fully integrated with the general pattern of training. (Para 5.11.1).

L. **Mental handicap**

29. Psychological services for the mentally handicapped should form part of the comprehensive Area service; psychologists who wish to specialise in this field should be able to reach the highest posts without leaving it. (Para 5.12.1).

M. **Services for children**

30. Although a decisive case has not been established for or against introducing a new discipline of child psychology, we believe closer co-operation is needed between clinical and educational psychologists. (Para 5.13.3).

# APPENDIX A

## COPY OF QUESTIONNAIRE SENT TO PROFESSIONAL AND OTHER ORGANISATIONS

**Standing Mental Health Advisory Committee**
**Sub-Committee on the Role of Psychologists in the Health Services**

*Questions for witnesses*

The Sub-Committee's terms of reference are "To consider the role of psychologists in the Health Services".

The purpose of the questions is to ascertain both present practice and the views of witnesses on the desirable content and organisation of psychological services in the re-organised health services.

It is recognised that many witnesses will be concerned only with a part of the area covered by the Sub-Committee's questions and witnesses are asked to answer *only* those questions on which they themselves wish to express views.

Witnesses who wish to comment on matters not covered by the questions are at liberty to do so but such comments should be restricted to matters within the terms of reference mentioned above. It should be noted however that the questions asked are the ones to which, in the Sub-Committee's present thinking, it will be most important to suggest answers.

Replies should be sent to the Secretary of the Sub-Committee, Mr I. Jewesbury, Department of Health and Social Security, Alexander Fleming House, Elephant and Castle, London SE1 6BY to arrive not later than 30 April 1973.

### A. THE CONTRIBUTION OF PSYCHOLOGISTS TO THE HEALTH SERVICES

What, in your view, is the contribution which psychologists (i) make and (ii) ought to make in the provision of *health* services for:

1. Pre-school-age children
2. Schoolchildren pre-puberty
3. Adolescents
4. Adults
5. The elderly?

The sub-committee would be glad to have the views of witnesses, in their answers to questions 1–5, on what this contribution is in the fields (where applicable) of:

(a) general assessment (particularly in questions 1–3)
(b) mental illness
(c) mental handicap (subnormality and severe subnormality)
(d) neurology and neurosurgery
(e) physical handicap

(Witnesses may find it useful, in answering these questions, to consider the division of psychologists' activities between:

(i) assessment and diagnosis
(ii) treatment and rehabilitation
(iii) research
(iv) other activities
For questions 1–3, witnesses may wish to take into account the direct role of *educational* psychologists in the provision of health services.)

6. What approximate proportion of the total time of psychologists working in the health services should be devoted to
(a) assessment and diagnosis
(b) treatment and rehabilitation
(c) research and teaching
(d) other activities?

## B. ORGANISATION OF PSYCHOLOGICAL SERVICES

7. What kind of psychological service organisation is needed at
(a) area level
(b) regional level?

8. Is there a place for providing psychological services directly to general practitioners or other professional staff working in the community such as social workers, health visitors etc?

9. Within the reorganised health services, should psychological services be provided from a hospital base?

10. How should district psychological services be organised if these are based in a hospital?
(a) in an independent Department of Psychology
(b) as part of the Department of Psychiatry
(c) other (please specify)

11. If there is an independent Department of Psychology:
(a) should it accept patients from non-medical sources?
(b) should it have its own in-patient, out-patient and day-patient facilities?

12. What arrangements should there be for
(a) hospital consultants
(b) general practitioners
(c) others
to refer patients to the psychological services for (i) opinion; (ii) treatment?

## C. CLINICAL RESPONSIBILITY

13. In the case of patients referred to psychologists for treatment
(a) by hospital consultants
(b) by general practitioners
(c) from other sources (if any)
where does clinical responsibility lie?

14. Under what circumstances, if any, should psychologists take overall clinical responsibility for patients referred to them?

## D. PERSONNEL

15. Are you able to say what staff are needed for a full psychological service at district level (population 200,000–250,000)
    (a) in districts not containing a teaching hospital?
    (b) in districts with a teaching hospital?
16. What scope is there for employing technicians in a district psychological service, and what types of work should be delegated to them?
17. What part have educational psychologists to play in the health services? (see also questions 1–3)

## E. STAFFING STRUCTURE

18. Does the present staffing structure for psychologists meet the needs of the service? If not, what alterations would you wish to see?

## F. TRAINING

19. Is the present training of clinical and educational psychologists adequate for the role they should undertake in the health services? If not, what changes are needed?
20. What should be the relative place of academic and practical training for health service psychologists? Should psychologists be employed who have only had in-service training not leading to a definitive qualification?
21. What kind of post-experience training is needed for psychologists in the health services, and what should be its frequency?

## G. TEACHING

22. What part do psychologists play at present in the teaching and training of
    (a) psychologists in training
    (b) medical students and doctors in training
    (c) doctors in vocational training
    (d) nurses (including health visitors)
    (e) social workers
    (f) other groups?
23. What part should psychologists play in the teaching and training of the above groups?

## H. RESEARCH

24. What is, and what should be, the role of health service psychologists in research?

## I. ANY OTHER COMMENTS

25. Are there any further points which you would like to make about the present role of psychologists in the health services or the ways in which this might be changed?

# APPENDIX B

## INDIVIDUALS AND ORGANISATIONS WHO GAVE EVIDENCE TO THE SUB-COMMITTEE

Association of Child Psychotherapists (Non-medical)
Association of Educational Psychologists
Association of Occupational Therapists
Association of Psychiatrists in Training
Association of Scientific Technical and Managerial Staff
Dr Martin Bax, Lecturer in Paediatrics, Guy's Hospital
Department of Mental Health, Queens University, Belfast
Dr J. L. T. Birley, Institute of Psychiatry
Department of Psychology, University of Birmingham
British Association for Behavioural Psychotherapy
British Association for Rheumatology and Rehabilitation
British Geriatrics Society
British Medical Association: Central Committee for Hospital Medical Services, General Medical Services Committee, Public Health Committee
Mental Health Sub-Committee of Council of British Paediatric Association
British Psychological Society
Division of Educational and Child Psychology of the British Psychological Society
Working Party on Teaching Psychology to Nurses of the British Psychological Society
British Society for the Study of Mental Subnormality
A. K. Broome, Clinical Psychologist, St George's Hospital, Morpeth
Irene Caspari and Elsie L. Osborne, Principal Psychologists, The Tavistock Clinic (Department for Children and Parents)
The Chartered Society of Physiotherapy
Mrs K. H. Clark, Didcot, Berks.
Committee of University Clinical Psychology Training Courses
H. A. Cook, Clinic for Nervous Disorders
Peter Cummings, Senior Educational Psychologist, City of Birmingham Education Committee
J. M. Curne, County Psychologist, Durham County Council
Dr J. Drummond, County Medical Officer, Surrey County Council
Avis M. Dry, Principal Clinical Psychologist, High Royds Hospital, Yorks.
Dr G. D. Duncan, SAMO, Regional Psychiatric Advisory Committee East Anglian Regional Hospital Board
University Staff in Clinical Psychology, University of Edinburgh
Executive Committee of the Division of Psychiatry for the Dumfries and Galloway Area
Dr W. I. Fraser, Consultant Psychiatrist, Lynebank Hospital, Dunfermline
General Medical Council
The Education Officer, General Nursing Council
V. Gorman, Principal Nursing Officer, Northgate and District Hospital
Dr P. J. Graham and Mr R. Lansdown, Department of Psychological Medicine, The Hospital for Sick Children, Gt Ormond Street
Dr H. C. Gunzburg, Consultant Psychologist, Monyhull Hospital, Birmingham
Dr R. S. Hallam, Psychological Treatment Section, Bethlem Royal and Maudsley Hospital

Health Visitors Association, Whitley Councils (Staff Side)
Hospital Consultants and Specialists Association
Institute of Mental Subnormality
Institute for Research into Mental Retardation
Dr D. C. Jones, Consultant Psychiatrist, Hensol Hospital, Glamorgan
Dr E. A. Lawson, Undergraduate School of Studies in Psychology, University of Bradford
Department of Psychology, University of Leeds
Department of Psychology, University of Leicester
Sub-department of Clinical Psychology, University of Liverpool
Department of Psychology, University College London
Dr T. R. Malloy, Consultant Child Psychiatrist, Booth Hall Children's Hospital
Dr Isaac Marks, Institute of Psychiatry
Dr J. McFie, Consultant Psychologist, Charing Cross Hospital
Mrs L. Mundy, Principal Psychologist, Wessex Unit for Children and Parents
Adrian Newell, Senior Clinical Psychologist, St James' Hospital, Leeds
K. A. Nichols, Department of Psychology, University of Exeter
Department of Psychology, University of Nottingham
Ian Oswald, Reader in Psychiatry, University of Edinburgh
Dr G. R. Outwin, Regent Square Group Practice
Oxford Regional Hospital Board
Dr Murray Park, Department of Psychological Medicine, Barnsley DGH
Dr K. R. D. Porter, SAMO, South-East Metropolitan Regional Hospital Board
Educational Psychologist, City of Portsmouth
Dr S. Rachman, Institute of Psychiatry
Mrs W. Raphael, Fellow of the British Psychological Society
Department of Psychology, University of Reading
Miss Pamela Rogers, Research Fellow, Royal College of Art
Royal College of Nursing and National Council of Nurses of the UK
Royal College of Psychiatrists
Royal College of Psychiatrists, Child Psychiatry Section
Dr C. S. Rushton and Dr J. R. Green, Educational Psychologists, Wiltshire County Council
Dr R. D. Savage, Department of Psychology, University of Newcastle-upon-Tyne
Dr M. B. Shapiro, Department of Psychology, Institute of Psychiatry
Sheffield Regional Committee of Senior Psychologists
Sheffield Regional Hospital Board: Working Party on Clinical Psychologists
Department of Psychology, University of Sheffield
Dr G. J. S. Simpson, Consultant Psychiatrist, Birch Hill Hospital, Rochdale
Society of Clinical Psychiatrists
Society of Community Medicine
Derek Thomas, Senior Clinical Psychologist, Industrial Unit and Adult Training Centre, Morpeth, Northumberland
Training Council for Teachers of the Mentally Handicapped
Dr D. A. Walk, Department of Child Psychiatry, St George's Hospital
Mr A. Wall, Group Secretary, West Somerset Hospital Management Committee
Dr Sula Wolff, Psychiatrist, Department of Psychological Medicine, Royal Hospital for Sick Children, Edinburgh
Dr Grace E. Woods, Consultant Paediatrician, Child Assessment Centre, Seacroft Hospital
World Health Organisation

# APPENDIX C

## INDIVIDUALS AND ORGANISATIONS WHO COMMENTED ON THE CONSULTATION DOCUMENT

Association of Educational Psychologists
Association of Scientific Technical and Managerial Staff
Association of University Teachers of Psychiatry
British Association for Behavioural Psychotherapy
British Association for Rheumatology and Rehabilitation
British Association of Social Workers
British Psychological Society
Chartered Society of Physiotherapy
College of Speech Therapists
Committee of University Clinical Psychology Training Courses
Department of Education and Science
Department of Employment
Mr B. Glaister, Principal Psychologist, Netherne Hospital
Hospital Consultants and Specialists Association
Institute for Research into Mental and Multiple Handicap
Institute of Health Service Administrators
Institute of Mental Subnormality
Institute of Psychiatry: Department of Psychology
Interim Regional Advisory Committee on Clinical Psychology, Birmingham
Mental Health Services Study Group of "Mensa"
National Association of Chief and Principal Nursing Officers
Professors of Psychiatry Club
Royal College of Midwives
Royal College of Nursing and National Council of Nurses in the United Kingdom
Royal College of Physicians
Royal College of Psychiatrists
Society of Chief Nursing Officers (Public Health)
Society of Clinical Psychologists
Society of Community Medicine
Dr R. W. Squier, Principal Psychologist, Hellingly Hospital
Tavistock Clinic, Department for Children and Parents
Training Council for Teachers of the Mentally Handicapped
University Grants Committee

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